STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	08/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT STREET GARY, IN46404

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F0000	This visit was for the Investigation of Complaint IN00095023. This visit was done in conjunction with the Recertification and State Licensure Survey. Complaint IN00095023 - Substantiated: Federal/State deficiencies related to the allegations are cited at F282, F315, F505, and F514. Survey Dates: August 15, 16, 17, 18, 19, 22, and 23, 2011 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Janet Adams, R.N. Kathleen Vargas, R.N. Census Bed Type: 125 SNF/NF 125 Total Census Payor Type: 17 Medicare 94 Medicaid	F0000	Allegation of Credible ComplianceThis plan of Correction is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed on pages 1-65 of this statement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance, please accept September 22, 2011, as the date of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	14 Other 125 Total Sample: 38 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/30/11 by Suzanne Williams, RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the plan of care were followed as written related to alarms and non-skid footwear not in use for 3 of 3 residents of the 5 who met the criteria for accidents. The facility also failed to ensure laboratory orders were obtained in a timely manner for 6 of 10 residents in the Stage 2 Sample of 38 who were reviewed for unnecessary medications. The facility also failed to ensure splints were on as ordered for 1 of 3 residents of the 8 who met the criteria for limited range of motion. The facility also failed to ensure medications were	F0282	1. Immediate action was taken for Resident F. Non-skid footwear was applied immediately. Interdisciplinary team met related to Resident F and Discontinued non-skid footwear as an ineffective intervention.Immediate action was taken for Resident H. interventions were reviewed on the date of this finding and with resident request, alarm sensor was removed and other interventions were put into place. The urine sample was collected but unable to correct due to event happening in the past.Immediate action was taken for Resident J who was placed in the correct wheelchair with correct interventions in place. The urine sample was collected but unable	09/22/2011

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	reduced for 1 of 10 residents in the Stage 2 Sample of 38 who were reviewed for unnecessary medications. The facility also failed to ensure medications were initiated in a timely manner for 1 of 1 resident of the 3 whose families were interviewed. (Residents #B, #C, #D, #E, #F, #G, #H, #J and #K) Findings include: 1. On 8/17/11 at 8:08 a.m., Resident #F was observed in a broda chair seated in the hall across from the nurses' station. The resident was wearing no shoes and had white socks on his feet. On 8/18/11 at 12:44 p.m. and 1:33 p.m., the resident was again observed in his broda chair. The resident had no shoes on and white socks on his feet. On 8/19/11 at 8:23 a.m., the resident was observed in his room in the broda chair. The resident had white socks on his feet and no shoes. At 11:00 a.m., the resident was observed in the broda chair in the main dining room. A pillow was observed on the footrest. The resident was wearing no shoes and was wearing white socks.		to correct due to event happening in the past.Immediate action was taken for Resident B. Unable to correct as resident was discharged from the facility.Immediate action was taken for Resident K. MD and family were notified during survey. Lab was obtained. Immediate action was taken for Resident G. Lab was obtained. MD and family made aware of result. Licensed staff received counseling on failure to transcribe orders properly. Immediate action was taken for Resident E. Licensed therapist completed screen on the day of this finding and the following day to ensure that there was no decline in range of motion. Splint applied. MD made aware of missing lab. New orders given and received. Resident on correct dosage for psychotropic medication. Unable to correct for timeliness due to event happened in the past. Immediate action was taken to review Resident C. However, unable to correct as event occurred in the past. Immediate action was taken to review Resident D. However, unable to correct as event occurred in the past. The infection noted in this alleged finding has resolved. 2. Residents will be identified by a 100% audit of resident clinical records which will be completed to check for fall devices, labs for the past thirty days, residents with use of splints, residents with	

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	The record for Resident #F was reviewed on 8/16/11 at 2:38 p.m. The care plan dated 6/17/11, indicated the resident was at risk for falls related to history of falls, and history of leaning over to left side while in bed. One of the approaches indicated staff were to ensure proper fitting shoes or non skid footwear were in use. Interview with CNA #5 on 8/22/11 at 9:25 a.m., indicated the resident had a history of rolling out of bed. She further indicated when the resident was gotten up in the broda chair, a pillow was put on the foot rest and the chair reclined slightly. Interview with the North Unit Manager on 8/22/11 at 10:37 a.m., indicated the resident was a fall risk but the intervention for non-skid footwear was not appropriate for the resident due to he does not walk and the care plan needed to be updated. 2. On 8/15/11 at 3:25 p.m., Resident #H was observed laying in bed. While walking up to the resident's bed and sitting in the arm chair next to bed, there was no evidence a sensor alarm was sounding or turned on by the resident's bed. On 8/16/11, at 2:22 p.m., the resident		psychotropic medication reductions for the past thirty days. Any findings corrected at the time of audit. 3. The system in place will be reviewed by nursing staff inservices to be held regarding devices for fall prevention, splint use, obtaining labs in a timely manner, medication administration in a timely manner, medication reductions in a timely manner. An audit tool has been developed to address devices for fall prevention, splint use, obtaining labs in a timely manner, medication administration in a timely manner, medication reductions in a timely manner.4. The system will be monitored by the Unit Manager / designee who will do a random audit three times per week for three months, then quarterly thereafter, to ensure fall devices are in place and working, splints are applied properly, labs and medication administration are done in a timely manner. The results of the audit will be forwarded to the QA Committee for their review and any concerns will be addressed. AddendumThe unit manager will audit 5 residents three times per week for three months, then quarterly thereafter.	

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	was out of her room. While walking around her room and around the resident's bed, there was no evidence a sensor alarm was not turned on and functioning. On 8/17/11 at 4:12 p.m., the resident was observed sitting on the side of her bed, while approaching her and standing approximately one foot from her bed, the sensor alarm did not sound. Further observation at that time, indicated the PCU Unit Manager entered the room and turned a switch on the sensor alarm that was located on the wall parallel to the resident's bed. The alarm immediately sounded. CNA #1 was observed to come into the room, she indicated that she did not know what the device was on the wall, and she had not idea what a sensor alarm was. Interview with LPN #1 on 8/17/11 at 4:22 p.m., indicated she had no idea Resident #H used a sensor alarm. Interview with LPN #2 on 8/17/11 at 4:24 p.m., indicated she was the nurse taking care of the Resident #H and she had no idea the resident had a sensor alarm in place. The record for Resident #H was reviewed on 8/17/11 at 8:23 a.m.			

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Review of the current plan of care plan dated 6/7/11, indicated the resident had the potential for fall related to a history of falls and an unfamiliar environment. The nursing approaches were to have sensor alarm, and a bed and chair alarm.

Interview with the PCU Unit Manager on 8/17/11 at 4:30 p.m., indicated the sensor alarm was to be in place after the resident had fractured her elbow.

Review of Physician orders dated 7/27/11, indicated urinalysis with a culture and sensitivity.

Review of the Lab results indicated the urine was not obtained until 7/29/11.

Review of Nursing Progress Notes dated 7/27 and 7/28/11, indicated there was no documentation of why the urine was not collected timely.

Interview with the PCU Unit Manager on 8/19/11 at 9:44 a.m., indicated the nurse who took the order for the urinalysis folded the order over with the intentions of transcribing it and following it through. However, the chart was placed back into the drawer and the orders were not carried out

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	until 7/29/11. 3. On 8/17/11 at 4:00 p.m. Resident #J was observed up in a wheelchair. There was a chair alarm noted to the chair, and there was a chair cushion on the bottom of the chair. On 8/17/11 at 4:13 p.m., CNA #1 was observed in the resident's room, at that time, she indicated she placed the resident in the wheelchair that she was currently sitting in. The CNA indicated she had thought this was the Resident #J's wheelchair. Further observation at the time, indicated the CNA was asked to stand Resident #J up from the chair. The PCU Unit Manager and CNA #1 then stood the resident up from the wheelchair. The chair alarm did not sound. Further observation indicated the chair alarm was turned off. There was also no dycem noted on top of the cushion or under the cushion in the wheelchair. The record for Resident #J was reviewed 8/17/11 at 3:30 p.m. The current plan of care dated 6/17/11, indicated the resident was at risk for falls. The nursing approaches were to have bed and wheelchair alarm and a dycem to the wheelchair.			

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Review of Physician orders dated 1/20/11, and on current 8/11 recap, indicated bed and wheelchair alarm check function and placement every shift.

Interview with the PCU Unit Manager on 8/17/11 at 4:30 p.m., indicated the resident was to have wheelchair alarm and a dycem to under her cushion while up in the wheelchair.

Further review of Physician orders dated 7/14/11, indicated to obtain urinalysis with a culture and sensitivity may straight cath.

Review of the Lab results indicated the urine was not collected until 7/19/11 (five days later).

Interview with LPN #3 on 8/22/11 at 10:13 a.m., indicated she was the nurse who usually works down on the unit with Resident #J. She indicated she was not working when the lab was ordered and written. She further indicated if staff were unable to obtain the urine sample then the Physician should have been notified.

Interview with PCU Unit Manager on

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	8/22/11 at 10:13 a.m., indicated the 24 hour report indicated the urine was collected and placed in the fridge on 7/17/11, however the lab has only 24 hours to pick up. She indicated the lab must not have picked it up timely so they had to collect another one. 4. The closed record was reviewed for Resident #B on 8/18/11 at 8:35 a.m. Review of Physician Orders dated 2/25/11, indicated an urinalysis weekly times three weeks. The Physician's order was clarified on 3/4/11 indicating order urinalysis weekly on Fridays. Review of the Laboratory findings indicated there was no urine collected in March or April 2011. Interview with the South Unit Manager on 8/18/11 at 2:22 p.m., indicated the facility only collected two urine samples from the resident during her entire stay. There were no samples collected in March or April 2011. **5. The record for Resident #K was** reviewed on 8/17/11 at 3:30 p.m. Review of the current Physician			

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	orders on the 8/11 recap indicated a Complete Blood Count (CBC) monthly. Review of the lab results dated 8/3/11, indicated the resident's Hemoglobin was 9.0 a low level. Further review on the bottom of the lab indicated the physician was notified and new orders to draw a CBC was to be done in one week. Review of the Lab results indicated there was no CBC completed on 8/10/11 or thereafter. Interview with the PCU Unit Manager on 8/19/11 at 1:23 p.m., indicated the CBC results were called to the physician, however, the nurse taking the telephone order did not transcribe it onto Physician orders, nor did she fill out a requisition for the lab to be drawn in a week. 6. The record for Resident #G was reviewed on 8/16/11 at 2:25 p.m. The resident was admitted to the facility on 8/4/11. The resident's diagnoses included, but were not limited to, diabetes mellitus and cerebral vascular accident (stroke). Review of the 8/4/11 admission orders indicated there was an order written for HgbAIC (a blood test to check blood			

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	sugars levels over a period of time) laboratory test to be completed on 8/10/11 and then every three months. Review of the 8/11 laboratory test results indicated a HgbAIC test had not been completed on 8/10/11 as ordered by the physician. When interviewed on 8/22/11 at 8:32 a.m., the facility Nurse Consultant #1 indicated nursing staff did not complete a requisition for the test to be completed and the laboratory did not complete the test as there was no requisition. 7. Resident #E was observed on 8/16/11 2:16 p.m. The resident was seated in her wheelchair in her room. There was no splint on her right wrist. On 8/16/11 at 3:59 p.m., the resident was observed seated in her wheelchair. There was no splint on the resident's right wrist. Continued observations on 8/17/11 at 9:41 a.m., 10:00 a.m. and 2:00 p.m., indicated there was no splint on the resident's right wrist. On 8/18/11 at 7:55 a.m. and at 2:07 p.m., the resident was observed with no splint on her right wrist.			

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	The resident was observed on 8/18/11 at 2:23 p.m. The resident did not have a splint on her right wrist. Interview with MDS Coordinator #2 on 8/18/11 at 2:23 p.m., indicated there was no splint on the resident's right wrist. The record for Resident #E was reviewed on 8/16/11 at 3:20 p.m. The resident had diagnoses that included, but were not limited to, diabetes, hemiplegia, anemia, seizures and schizophrenia. The Quarterly MDS (Minimum Data Set) assessment, completed on 8/3/11, was reviewed. The assessment indicated the resident had functional limitations in range of motion on both upper extremities. A care plan, dated 8/5/11, indicated the resident had a potential for decline in passive range of motion related to decreased mobility. One of the interventions was to have left and right hand splints on as ordered. A care plan, dated 8/5/11, indicated the resident needed splinting to her bilateral wrists related to decreased mobility. The goal was to wear splints to her bilateral wrists 6 times per			

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	week. The interventions to be used included: -apply splint in a.m. take off in p.m. -explain procedure to resident -monitor splint area for skin integrity and cleanliness -notify nurse of any changes -perform range of motion to extremity for splint application Interview on 8/18/11 at 2:23 p.m., with Restorative CNA #4, indicated she had not applied any splint to the resident's right wrist. She indicated therapy discontinued the use of the resident's splint for her right wrist. She indicated that she applied a wrist splint to the resident's left hand when the resident was up in the chair and placed the white palm protector in the left hand when the wrist splint was removed. Interview with the resident on 8/18/11 at 2:25 p.m., indicated she had not used any splint on her right wrist. Interview with MDS Coordinator #1 on 8/18/11 at 2:15 p.m., indicated the resident did not have splints to both her right and left wrists as indicated on the resident's care plan.			

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	The June 2011, July 2011 and the August 2011 Physician Order Sheets for Resident #E were reviewed. There were physician's orders for a monthly CBC (complete blood count) and a biweekly Dilantin (a medication used for seizures) level to be drawn. A Dilantin level was obtained on 7/14/11, there was not another Dilantin level obtained until 8/10/11. Interview with the 200 South Unit Manager on 8/22/11 at 1:30 p.m., indicated the Dilantin levels were not drawn bi-weekly as ordered by the physician. The CBC results were reviewed. There were results for CBC levels that were obtained on 8/10/11 and 7/13/11. There were no CBC results for the month of June 2011. Interview with the 200 South Unit Manager on 8/19/11 at 2:02 p.m., indicated a CBC was not drawn in June 2011 as ordered by the Physician. A form titled "Consultant Report" with Resident #E's name and dated 2/2/11, was reviewed. The pharmacist had recommended that the resident's Risperdal (an anti-psychotic			

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	medication) be reduced from 2 mg (milligrams) twice daily. The recommendation was to change the Risperdal to 2 mg in the a.m. and 1 mg in the p.m. The physician signed the form on 3/8/11 and indicated that he accepted the recommendation and wanted the medication to be reduced. Review of the physician's orders indicated the recommendation was not followed through until 4/7/11. There was a physician order dated 4/7/11 that indicated to discontinue the Risperdal 2 mg twice daily and to start Risperdal 2 mg at 9:00 a.m. and 1 mg at 5:00 p.m. Interview with the 200 South Unit Supervisor on 8/18/11 at 1:57 p.m., indicated the physician's order to reduce the Risperdal was not followed through timely. She indicated the medication should have been reduced on 3/8/11 when the physician signed the consultant report. 8. The record for Resident #C was reviewed on 8/16/11 at 2:40 p.m. The resident had diagnoses that included, but were not limited to, cancer of the rectum and diabetes.			

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	155580	A. BUILDING 00 B. WING	08/23/2011

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	There was a physician order, dated 4/1/11, that indicated "May straight cath (catheterize) resident for ua (urinalysis) if unable to void." Review of the laboratory tests indicated a urinalysis was not obtained until 4/8/11, seven days after the physician ordered the urinalysis to be obtained. Interview with the 200 South Unit Manager on 8/21/11 at 9:15 a.m. indicated the urine sample was not obtained timely as ordered by the physician. 9. The record for Resident #D was reviewed on 8/16/11 at 2:20 p.m. An entry in the nursing progress notes, dated 8/2/11 at 3:30 p.m., indicated, "...daughter complains of mouth odor, writer assessed resident , coated tongue, with foul odor noted, no complaints of pain at this time...." The physician was notified on 8/2/11 of the resident's oral status. There was a physician order, dated 8/2/11, that indicated, "Nystatin (an antifungal medication) solution 10 cc (cubic centimeters) po (by mouth) swish and swallow bid (twice daily) x 14 days." A nursing progress note, dated 8/5/11 at 2:12 p.m., indicated, " ...writer			

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	notes calling pharmacy due to medication nystatin solution not deliver at this time, writer notes speaking to pharmacy tech, and did receive statement of not receiving physician order for the nystatin solution, pharmacy tech did request writer to read order to the pharmacy tech and did receive statement that the nystatin solution well be send out with other medications tonight [sic]...." Observation on 8/18/11 at 8:33 a.m., indicated the label on the Nystatin medication bottle was dated 8/5/11. Interview with LPN #4 at that time, indicated the medication was delivered on 8/5/11. Interview with the 200 South Unit Manager on 8/17/11 at 12:30 p.m., indicated the Nystatin was ordered on 8/2/11. She also indicated the medication was not initiated timely. This federal tag relates to Complaint IN00095023. 3.1-35(g)(2)			

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F0315 SS=G	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interviews, the facility failed to ensure the resident received the necessary treatment and services to treat an urinary tract infection when a resident was exhibiting signs and symptoms of an urinary tract infection for 1 of 3 residents reviewed for urinary tract infections of the 3 who met the criteria for urinary tract infections. Findings include: The closed record was reviewed for Resident #B on 8/18/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, seizures, pneumonia, and neurogenic bladder. The resident was admitted to the facility on 2/25/11. The resident was admitted to the hospital on 4/23/11 and returned to the facility on 5/11/11 with an indwelling foley catheter. The 5/26/11 catheterization evaluation	F0315	1. Immediate Action could not be taken for Resident B as the the resident had been discharged from the facility. 2. Other residents having the potential to be affected were identified by lab reports from the last thirty days indicating residents with urinary tract infections. Those residents' charts with indwelling catheters were audited to ensure appropriate treatments and services were in place to prevent urinary tract infections. Any abnormal findings were reported to MD and family.3. The system in place will be reviewed with Nursing staff by inservice training related to obtaining labs, signs, symptoms and treatment of urinary tract infections. An audit tool will be utilized to ensure urine samples are collected and sent to lab with MD and family notification of results. 4. The system will be monitored by the Director of Nursing/designee by auditing five charts per week for three months and then quarterly thereafter until compliance has been met. The results of the audit will be forwarded to the QA committee	09/22/2011

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	indicated the resident had the diagnoses of neurogenic bladder/atonic bladder and the resident was to have a catheter indefinitely due to multiple sclerosis. Review of Physician Orders dated 5/11/11, indicated urinalysis every week for three weeks then monthly. Review of the laboratory data indicated the first urinalysis obtained was not until 5/23/11. The final culture dated 5/27/11 indicated greater than 100,000 entercoccus faecium. The organism was resistant to vancomycin and penicillin antibiotics. The organism was susceptible to tetracycline and linezolid antibiotics. Review of Nurses Notes dated 5/25/11, indicated the resident had a seizure and was sent out to the emergency room at 6:32 a.m. The resident returned to the facility on 5/25/11, at 3:00 p.m. with Physician orders for an antibiotic for an urinary tract infection. Review of Physician Orders dated 5/25/11, indicated Bactrim DS 800-160 milligrams (mg) one tab by mouth twice a day times seven days.		for their review.	

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	Review of Nurse's Notes dated 5/27/11 indicated the resident's Physician was not made aware of the culture results of the 5/23/11 urinalysis. Review of the laboratory results indicated the next urinalysis obtained was on 6/7/11. The final culture was dated 6/8/11 which indicated 60,000 to 70,000 multiple gram positive organisms. The resident's physician was notified and no new orders were obtained. Nurses notes dated 7/7/11, at 8:09 p.m., indicated the resident's urine was cloudy and yellow in color with slight hematuria (blood in the urine). Review of Physician orders dated 7/7/11, indicated to obtain an urinalysis with a culture and sensitivity. The next entry in Nurses Notes for an urine assessment was 7/8/11, at 1:55 a.m., which indicated the urine was yellow and cloudy with no odor or sediment in the tubing. The next entry for an urine assessment was on 7/8/11 at 3:31 p.m., which indicated the urine was yellow with no hematuria noted. The			

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	urine sample was in the refrigerator awaiting lab pick up. The next documentation about the resident's urine was not until 7/11/11 at 8:49 p.m., which indicated the urine was yellow with mucous threads noted. Nursing Progress Notes dated 7/17/11, at 9:08 p.m., indicated called to room at 8 p.m. by other staff due to change in level of consciousness, excessive frothy sputum in mouth. Resident found to be postictal (after seizing). Urinary output was decreased. The physician was notified and new orders were obtained to start an intravenous line with D5 .9 normal saline give 200 cubic centimeters (cc) bolus then 100 cc an hour thereafter. Urinary output was to be monitored. Another entry in Nursing Progress Notes was on 7/17/11 at 9:36 p.m., which indicated there was no urinary output and the intravenous fluids were infusing without problems. On 7/18/11 at 3:13 a.m. Nursing Progress Notes indicated the resident appeared lethargic and there was some yellow urine observed in the foley bag.			

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	On 7/18/11 at 4:30 p.m. Nursing Progress Notes indicated at 9 a.m., resident was lethargic and not responding and had a seizure which last over 20 minutes. The resident's physician was notified and new orders were obtained to send to the hospital. Review of the laboratory results indicated there were no results for urinalysis that was collected on 7/8/11 and placed in the refrigerator. Interview with South Unit Manager on 8/19/11 at 2:27 p.m., indicated she had called the lab and they indicated they did not receive an urine sample from the facility for Resident #B. Review of Physician orders dated 5/11/11 indicated to change the resident's foley catheter every two weeks. Review of the Medication Record for 6/11 indicated the foley catheter was changed on 6/3/11 and 6/24/11. Review of the 7/11 Medication Record indicated the foley catheter had not been changed from 7/1-7/18/11. Review of a urinalysis that was completed in the hospital on 7/18/11 indicated greater than 100 white blood cells, 1 plus bacteria, 2 plus blood, 20-50 red blood cells. The			

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	final urine culture was dated 7/20/11 which indicated 70-80,000 proteus mirabilis pipercillin and greater than 100,000 multiple gram positive organisms indicating an urinary tract infection. Interview with the South Unit Manager on 8/19/11 at 2:25 p.m., indicated the foley catheter was not changed every two weeks as ordered and was not changed in July 2011. She further indicated the facility only collected two urine samples from 5/11/11 and the one sample collected on 7/8/11 was not sent to the lab. The South Unit Manager also indicated at the time, the resident was sent out to the hospital on 7/18/11 and did not come back to the facility. This federal tag relates to Complaint IN00095023. 3.1-41(a)(2)			
F0505 SS=D	The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to promptly notify the resident's physician of laboratory results related to a dilantin level and an urine culture for 2 of 10 residents reviewed for unnecessary	F0505	1. Immediate action could not be taken for resident B as this resident had been discharged from the facility. Immediate action was taken for resident H who was not exhibiting any signs and	09/22/2011

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	medications. (Residents #B and #H) Findings include: 1. The closed record for Resident #B was reviewed on 8/18/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, seizures. Review of Physician orders dated 2/25/11, indicated a dilantin level was to be drawn every week. Review of the laboratory results dated 3/17/11, indicated the phenytoin level (dilantin) was 5.9 (normal was 10-20) a low level. Review of Nurses Notes indicated there was no entries on 3/17 or 3/18/11. There was no documentation the physician was notified of the low dilantin levels. Nursing Progress Notes dated 3/19/11 at 10:39 p.m., indicated the resident had a seizure and was admitted to the hospital. Interview with the South Unit Manager on 8/18/11 at 2:25 p.m., indicated there was no documentation in the resident's record the physician was notified of the low dilantin level. 2. The record for Resident #H was		symptoms of infection. Unable to correct timely response due to event happened in the past. 2. An audit of all residents who receive labs, for the past 30 days was conducted to identify and ensure labs were obtained. Those identified in error families and doctors were notified of abnormal findings. 3. The system in place will be reviewed via inservice training for all licensed nurses on MD notification of labs will be completed no later than September 22, 2011.4. Compliance will be monitored by an audit tool which has been developed for use by the unit managers /Designee to audit at least five residents two times a week for completion of labs for one month then quarterly until 100% compliance has been met. Results of audit will be presented in monthly QA meetings.	

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	reviewed on 8/17/11 at 8:23 a.m. Review of Physician orders dated 7/27/11, indicated an urinalysis with a culture and sensitivity were ordered. The urine was collected on 7/29/11 and sent to the laboratory. Review of the urine lab results indicated a culture and sensitivity was performed with the final report faxed to the facility on 8/1/11. The culture indicated the resident had an urinary tract infection with greater than 100,000 Escherichia Coli. At the bottom of the lab results, the nurse indicated the results were faxed to the physician on 8/1/11. Review of Physician orders dated 8/3/11, indicated an antibiotic for the urinary tract infection was not ordered until 8/3/11. Review of current 9/05 Physician Notification for Change in Condition policy provided by Nurse Consultant #1, indicated Immediate Notification Problems: These require direct communication with the physician and may not be faxed. Positive urine culture over 100,000 of a pathogen. Interview with the PCU Unit Manager on 8/18/11, at 9:44 a.m., indicated the resident's physician insists that all of			

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	his lab results be faxed regardless of the results. She indicated she was unaware of the facility's policy about all infections greater than 100,000 must be called to the doctor and not faxed. This federal tag relates to Complaint IN00095023. 3.1-49(f)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the resident's medical record was accurate related to the transcription of a dietary supplement for 1 of 3 residents reviewed for nutrition of the 7 who met the criteria for nutrition. (Resident #B) Findings include: The closed record for Resident #B	F0514	1. Immediate action was not applicable for Resident B as this resident had been discharged from the facility. 2. Current resident's charts will be reviewed for any transcription errors. The physician and family will be contacted regarding any discrepancies noted. 3. The system in place will be reviewed via In-service training on transcribing orders for all licensed nursing staff which will be completed no later than	09/22/2011

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	was reviewed on 8/18/11 at 8:35 a.m. The resident's diagnoses included multiple sclerosis. The dietary progress note dated 6/22/11 indicated the resident had a significant weight loss of 15% in the last 90 days. The resident has had gradual weight fluctuations. The resident was fed by staff. The Dietitian had recommended healthshakes with breakfast and dinner which would provide an extra 200 calories and six grams of protein per shake to increase caloric intake and avoid unintentional weight loss. Review of Physician orders dated 6/23/11 indicated healthshakes twice a day at breakfast and dinner. Review of the Medication Administration Record (MAR) dated 6/11 indicated the healthshakes were transcribed onto MAR as "healthshakes BID (twice daily) at breakfast and lunch" with the times of 1200 (12:00 p.m.) and 1700 (5:00 p.m.). Further review of the MAR indicated the healthshakes were signed out as being given at those times from 6/23-6/30/11. Review of the MAR for 7/11 indicated the healthshake order was not		September 22, 2011.4. Systemic changes will be monitored by Medical Records/Designee whom will audit at least five charts per week times four weeks then quarterly thereafter. Results will be presented in monthly Quality Assurance meetings.	

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	transcribed onto the medication sheet. There was no documentation of healthshakes being given to the resident or the consumption of the healthshake from 7/1-7/18/11. Interview with the South Unit Manager on 8/18/11 at 2:25 p.m. indicated the healthshakes were not transcribed onto the 7/11 MAR as ordered by the doctor. She further indicated the times for the healthshakes were transcribed for lunch and dinner on the 6/11 MAR. She also indicated at that time the nurses were to monitor the consumption of the healthshakes. This federal tag relates to Complaint IN00095023. 3.1-50(a)(2)			